

<b>Case Number:</b>	CM15-0009554		
<b>Date Assigned:</b>	01/27/2015	<b>Date of Injury:</b>	01/01/1997
<b>Decision Date:</b>	03/23/2015	<b>UR Denial Date:</b>	12/17/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/16/2015

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California, Arizona

Certification(s)/Specialty: Physical Medicine & Rehabilitation

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The injured worker is a 71-year-old male who reported an injury on 01/01/1997. The mechanism of injury was not provided. The mechanism of injury was not provided. Prior therapies and treatments included an MRI and lumbar epidural steroid injection. The documentation of 11/10/2014 revealed the injured worker had low back pain and bilateral knee pain that was sharp and constant. The injured worker was noted to be utilizing hydrocodone to alleviate pain. The objective findings revealed decreased range of motion and a sensory deficit of the bilateral legs. The injured worker had a positive valgus test on the left and a positive drawer sign along with crepitus and peripatellar swelling. The diagnoses included lumbar disc disease, lumbar radicular signs and symptoms, cervical disc disease, and history of a right total knee replacement in 2007 and left knee open reduction and internal fixation with hardware in 1991. The treatment plan included Norco 10/325 #150 with no refills.

### IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

**Norco 10/325mg #150:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 79-80.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic pain; ongoing management Page(s): 60; 78.

**Decision rationale:** The California Medical Treatment Utilization Schedule Guidelines recommend opioids for the treatment of chronic pain. There should be documentation of objective functional improvement, an objective decrease in pain, and documentation the injured worker is being monitored for aberrant drug behavior and side effects. The clinical documentation submitted for review failed to indicate the injured worker was being monitored for aberrant drug behavior and side effects. There was a lack of documentation of objective functional improvement and an objective decrease in pain. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for Norco 10/325 mg #150 is not medically necessary.